MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, September 12, 2002
10:14 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM: Preliminary results from the survey of physicians about Medicare -- Julie A. Shoenman, Project HOPE; Kevin Hayes

DR. HAYES: We have with us today Julie Shoenman from Project HOPE, who will be presenting the preliminary results of this survey. Before I turn things over to Julie, though, let me just say a couple of words about the purpose of this survey, why we sponsored it, and also give you some background on how we came to develop this particular survey, how we built on our experience with the previous survey that the Commission sponsored, one in 1999.

As to the purpose, of course we heard this morning about how access is in our method for assessing payment adequacy and making update recommendations. So certainly a survey of this sort feeds right into that kind of a process.

We sponsored, as I said, that last survey in 1999, and considered doing another survey last year. It just seemed like we were about due to do another one, but decided to hold off because of the anticipation of a payment reduction for physician services. It seemed like this would be the better year to do such a survey. And it seems like the timing is good. The payment reduction turned out to be larger than we had anticipated initially.

Beyond that, we have of course a great deal of interest in access issues right now, not only because of the payment cut but the Congress is considering legislation to change the way payments are updated for physician services. There was recently the results of an online survey by the American Medical Association released which talked about physician acceptance of Medicare patients and other aspects of medical practice.

In your mailing materials for this meeting, you received an issue brief put out by the Center for Studying Health System Change, which talked about not just access to care for Medicare beneficiaries, but others as well, and showed that it appears that there is some problems with access not just for Medicare beneficiaries but for others.

We don't know whether these changes that we're seeing are transitory or part of something more fundamental, and all of that just lends further importance to this approach of continuing to monitor beneficiary access to care, as we discussed this morning.

As to building on the earlier survey, let me just say first that we reviewed the earlier questionnaire, the

one from the 1999 survey, and dropped some questions that seemed no longer relevant, added some questions on topics that were more timely. I'm thinking in particular about the regulatory burden study that the Commission did last year. All those things were an integral part of conducting this year's survey.

We also reviewed the transcript from the March '99 Commission meeting where the Commission talked about the results of that earlier survey. And that review led us to change some of the questions on the questionnaire. We had, for example, as you'll see in a moment, we talk about physician acceptance of patients, not just Medicare patients, but patients with other sources of payment. And there were some concerns in the earlier survey about the categories of payers that we used. We revised those. I talked to a few of you informally about the categories that we used this time, and we hope that we have that right now.

We also added some more detail on the way physicians are changing their practices. For example, in the earlier survey we had talked about physicians reducing their staffing costs. Based on comments we received earlier, we've made that question more specific, to ask not just about reducing staff costs but reducing the number of staff.

So anyway, that's kind of how we came to do this survey this time around. What I'd like to do now is to turn things over to Julie. Julie Schoenman is a senior research director at Project HOPE. She worked with a team of others at Project HOPE, as well as the Gallup organization, to design the survey, collect the data, and analyze the preliminary results that we'll see today. We're very fortunate to have such an experienced team working on the survey and look forward to Julie's presentation.

DR. SCHOENMAN: Thank you, Kevin, and thank you for having me here. I'm anxious to present the preliminary results of the survey and get your feedback on what we've done.

As Kevin said, the purpose of this survey was to monitor access and other aspects of practices, especially in light of the most recent fee changes. It was very similar to the '99 survey that was conducted by MedPAC. Gallup collected the data using three different interview modes.

We began data collection in April of this year, which was a date that we chose specifically because it was several months after January and we wanted to give

physicians several months to sort of gain knowledge and experience with the fee changes and perhaps react to those changes, make some changes in their behavior.

Gallup has just recently finished the data collection the very end of August. So what I'm presenting to you today is based on a preliminary database that reflects about 700 responses that had come in by the late July period.

DR. NEWHOUSE: This is all specialties?

DR. SCHOENMAN: It's all specialties except for a few, pediatricians of course, the classic exclusions. But yes, it's all specialties.

In both '99 and 2002, there were several criteria for being eligible for the survey, but one critical one was that the physician had to spend at least 10 percent of his time with fee-for-service Medicare patients. Bias does not exist, as it were, but we don't have physicians in there who are seeing very few Medicare patients. So when you look at acceptance of new patients, those physicians aren't in there. But we wanted to get physicians who had enough experience with the program to give us informed opinions about how things stacked up.

The first line of inquiry dealt with their overall concerns with medical practice. These were not specific to a particular payer. We asked in general, for your practice as a whole, how concerned are you about the various factors that you see listed there. They could say they were anywhere from extremely concerned to not at all concerned.

What you see is there was the most concerned expressed about reimbursement. This is not Medicare-specific, it's in general, about reimbursement. And relatively less concern about external review of clinical decisions and the timeliness of claims payments.

Those patterns held pretty much when you add the category very concerned. Again, billing paperwork and reimbursement are the most concern to physicians, and the timeliness of payments and external review are relatively of less concern.

For the first four of those factors listed there, we also asked physicians to rate their level of concern relative to various payers. Fee-for-service Medicare was one of those payers and what we see here is how their concerns within the Medicare program stack up.

We also had one other question about how concerned were they about Medicare's actions in pursuing fraud and

abuse investigations with the same extremely concerned to not at all concerned scale.

So here you can see that among all these factors, they're most concerned about reimbursement within the Medicare program. And they're relatively less concerned about the timeliness of payment and external review. And those patterns hold again, when you add the very concerned category reimbursement is still the factor that is generating the most concern among physicians within the fee-for-service Medicare program.

We are able to compare their concern ratings that they gave for fee-for-service Medicare to how they rated other payers on these same factors. These other payers were private fee-for-service/PPO, the indemnity plans, Medicaid which includes Medicaid HMOs, and then other HMOs which is where Medicare+Choice, the Medicare HMOs, should be classified there.

And then we had another question that asked them how difficult was it to get timely and accurate billing and coverage information from these various insurers. So that's the last row of the table.

What we see when we compare fee-for-service Medicare is that Medicare does better than other HMOs on factors that you'd think of as related to administrative hassles, the administrative paperwork, the timeliness of payments, and just the ease of dealing with Medicare as an insurer. And Medicare also does better than Medicaid on ease of getting information from the insurer.

However, Medicare does worse on external review than either the private indemnity plans or Medicaid. That's despite the fact that overall on the prior slide we saw that physicians weren't terribly concerned about external review. The other factors were of much more concern to them. They still are more concerned about it under Medicare than they are for these other types payers. I think that's the fraud and abuse angle of Medicare that's coming into play there.

Finally, we see that they are more concerned about reimbursement for Medicare than they are relative to the private indemnity plans.

Because there's so much interest in the fee changes, we asked a couple of questions just to assess physicians' knowledge of the fee changes. First we said are you aware of the 2002 changes? And we found that two-thirds of the physicians said they were aware of those changes.

Now in 1999 we had a similar question on that

survey that said are you aware of the Medicare fee changes that have taken place since 1997? Those were the practice expense changes and the single conversion factor, just to give you an idea of what they were being asked about the prior time. And we found very similar results. Again, two-thirds in the earlier survey were also aware of these changes.

So while the majority are aware of what is happening to their fees, it's no greater awareness this time around than it was with respect to the prior changes.

In this survey, if they said they were aware of the changes, we asked them has it increased or decreased your Medicare revenue? And 91 percent said it, in fact, had decreased their revenue. So they're right on target there. And that was higher than the percent that we got in the prior survey, when in fact some physicians could have seen increases.

DR. NELSON: I'm sorry I didn't ask it when you were talking about the sample you surveyed, but do you have any idea what percentage of the sample was composed of physicians who are, for example, employed by a university or in an employed status where they are so insulated from payment implications that they wouldn't be aware, because they don't have to?

DR. SCHOENMAN: Right. It's quite possible. We do ask a question at the very end of what their practice type is and university full-time faculty is a category that we can look at. I don't have those numbers with me.

In terms of awareness, everyone was asked those questions. The level of concern, they actually to have 10 percent of their practice not only from Medicare but for every other payer types, in order to get into the analysis that I was presenting earlier. So it's physicians who had at least some knowledge with whatever insurer we were talking about.

Let's turn now to the acceptance of new patients, which is one of our most critical ways of monitoring access to care. The first question that we asked was just, in general, are you accepting any new patients of any type, regardless of payer? In other words, is your practice open? 92 percent of physicians said that they had open practices, which was about what we had seen in the '99 survey.

For those with open practices, we then said are you accepting all, some, or no new patients with the different types of insurance? And here you see the '99 and

2002 results. The bars represent the sum of the all category plus the some category. So what you'd see is things look pretty good for Medicare when you look at it this way. 96 percent of physicians say they're accepting at least some new fee-for-service Medicare patients. Only acceptance of private indemnity patients is higher. And you can also see the Medicaid acceptance is low to start with and has declined significantly in the three years that elapsed between the two studies.

This slide, though, is a bit misleading because it masks the difference between the acceptance of some new patients and all new patients. So in this slide it's exactly the same bars that you saw in the prior slide, but the blue represents the all new patients and the red is the some new patients. What you see immediately is that for the fee-for-service bars, there's a decrease in the size of the blue bar. There's a 7 percentage point decline in the percent of physicians who say that they accept all new patients, which could be distressing.

However, when you look at all of the other payer types, except for the private indemnity, you see the same type of tightening in access, the same sort of systemic situation.

We also wanted to explore what would be driving some of the acceptance decisions. So we asked specifically, for some of the factors that we had talked about before. If a physician had said that he or she was concerned or very concerned or extremely concerned about reimbursement, they got a follow up question that said has this concern led you to limit the number of new patients you accept with whatever type of insurance you're talking about?

So what we see in this graph, the red bars show overall, for all the physicians who got the follow up question for that particular type of insurer, how many said yes, in fact, they were limiting access. And what you see is there are red bars. So that means that acceptance of patients is being affected by the physician's concerns about reimbursement. You also see the restrictions that are in effect for fee-for-service Medicare are right on a par with the restrictions for the private indemnity patients. And they're lower, much less pronounced than the restrictions that we see for Medicaid or HMO patients.

The other thing, the blue and the yellow and the green bars just show that the higher the level of concern about reimbursement, the more likely the physician is to say

that he or she was limiting the number of new patients accepted.

We asked an identical series of questions that related the concerns about billing paperwork to acceptance of new patients. You see the graph looks almost identical to what we just saw for reimbursement. So all of the same points that we made about reimbursement hold for this billing paperwork, as well. So there are restrictions in access not only to reimbursement concerns but also to billing paperwork concerns.

DR. NEWHOUSE: Medicaid HMO adds more than 100 points?

DR. ROWE: No, they're different. The red is different than the other three things.

DR. SCHOENMAN: It's 54 percent of those who said they were extremely concerned about paperwork under Medicaid said they were limiting access.

DR. ROWE: It doesn't mean those three are equally sized. The three subsets don't have to be equal size. So 54 percent of the people who are extremely concerned and limiting access, that may only be 100 doctors.

DR. SCHOENMAN: A bit misleading, but that's the right interpretation.

There was one other question that was specific only to Medicare, which was had their concerns about the Medicare's fraud and abuse investigations or possibility of being investigated led them to limit the acceptance of Medicare patients. 8 percent said yes, that they had limited patients because of those concerns. It's a lower magnitude, but it's still occurring.

And again, the more concerned they were about the factor, the more likely they were to be limiting.

MR. SMITH: The percent limiting access, is that the sum in the no categories?

DR. SCHOENMAN: This is a question, it's a yes or a no. Did this concern lead you to limit your acceptance?

MR. SMITH: So we don't know whether they've cut it off.

DR. SCHOENMAN: It's just that they have made some restrictions in their acceptance of new patients with that type of insurance.

We considered a couple of other measures of access in addition to acceptance of new patients. First of all, we asked about how difficult is it to find suitable physicians or surgeons to whom to refer your patients with different

types of insurance. What we found when we compared the answers for the different payers was that they viewed referral of fee-for-service Medicare patients as being more difficult than for their private indemnity patients and less difficult than for their Medicaid and HMO patients.

We also asked about in the past year have you made any change at all to the priority that you give to fee-for-service Medicare patients who are seeking appointments with you? 11 percent said yes to that question, that they had changed their appointment priority. Now some of those physicians were increasing the appointment priority. It ran about two to one. They were about twice as likely to have decreased the priority than to have increased among those 11 percent that reported a change.

The appointment priority was more likely to have been decreased if the physician was aware of the fee changes in 2002, if they thought those fee changes had reduced their revenue, or if in general they had been reporting greater concerns about the various practice factors related to the Medicare program.

So what do we take away from all of this? I think there are a few points. It seems that physicians are quite knowledgeable about the fee changes. They are concerned about the fee changes, particularly relative to the reimbursement under private indemnity plans. We have seem some tightening in access for fee-for-service Medicare beneficiaries.

However, the access restrictions, the movement away from the blanket acceptance of all new patients was seen for all other payer types as well, other than the private indemnity patients.

And we see that there have been access restrictions related to their concerns about reimbursement, but that there were also restrictions related to other factors, like billing paperwork and to a lesser extent fraud and abuse concerns. And that these restrictions that we saw for Medicare, they were on a par with the private sector indemnity plans and they were much less than the restrictions that were being reported for Medicaid and for HMOs.

Thank you. I'd really appreciate your comments and feedback.

MR. HACKBARTH: Last year when we discussed physician fees one of the questions that we touched on was whether we should recommend rollback of the 5.4 percent

reduction that was scheduled for 2002. And ultimately, we decided not to recommend that. As I look at these data, personally I guess I draw some comfort from them. Even in the wake of that 5.4 percent reduction we still have 96 percent of physicians accepting at least some new Medicare patients.

With however, a very important caveat, which is that these are national average data and so they don't speak to problems that may exist in particular geographic locations or in particular specialties. That's just my overall reaction to these.

Of course, looking forward, the potential for the additional cuts scheduled under current law, given this response to the initial cut I guess, is a little bit scary. What would happen after year two, year three cuts occurred?

Other comments?

DR. ROWE: Just a couple comments, Julie, or questions. One is that I think it would be interesting to see what proportions of variance with respect to some of these variables, particularly with respect to acceptance of some Medicare beneficiaries could be explained or associated with age. Age of physician or years of practice or date graduated med school or some measure of the duration that they've been in practice.

I think that, in my experience, may times younger physicians building their practice, or who cannot see the horizon of their retirement or whatever, are much more likely to accept new patients of all sorts, and older physicians, closer to their retirement, changes in their lifestyle, different referral patterns, et cetera, might be less so.

That may be wrong, but if you have any data that would be a proxy for that, I think it would be worth asking that question.

DR. SCHOENMAN: We actually do. We have the date of birth. We can look at their age.

DR. ROWE: Age is a proxy for it. Some people go to med school later, but in general --

DR. SCHOENMAN: I believe we actually went back, excuse me, on the sampling frame and had that put back onto the sampling frame, the date of graduation. So we can do both.

DR. ROWE: That's great. I think that would be interesting. Secondly, I think it would be interesting if we could find some comparable data that give us a

longitudinal perspective. For instance, the percent of physicians with concerns, be it extreme or less extreme or very concerned, with respect to billing paperwork reimbursement. It would be interesting to look back, maybe even 20 years ago when everybody in retrospect thinks reimbursement was pretty good, to see what percent of physicians felt that they were not being adequately compensated.

To see whether or not we've made any change, or these are traits not state measures. I think it would be informative, as we look at these individual cross-sectional snapshots, so that we don't overreact one way or the other to, in fact, have some sense of whether or not there is any capacity for these things to move in one direction or another over time.

The last point I would make is I'd be interested in the billing paperwork question over time specifically, because there are vacuums or aliquots of physician practices in which auto-adjudication of claims has increased very dramatically over the past several years. Many physicians now might have, if they have a largely HMO practice, 65 percent of their claims might be auto-adjudicated, so much less paperwork.

One would expect that if that is really the case, that this complaint would start to erode. I don't know if we can identify specific practices. Alice may have a better idea about this than I, or Allen, where there would be a higher penetration of such auto-adjudication presumptively. And therefore, you could look at those.

But I think that would be interesting because after all, it's in the best interest of everyone, the patient, the health plan, and the doctor to auto-adjudicate these claims, if we can do that.

MS. ROSENBLATT: Jack, do you mean auto-adjudication or electronic submission, or both?

DR. ROWE: I think I mean both of those, thank you. EDI or web-based. But a paperless transaction, if you will, Alice.

I don't if you agree with my point of view or not, but I think there have been some advances here.

MS. ROSENBLATT: I think it is a good point, but it is both criteria.

DR. ROWE: It's both, yes. Thank you. Those are my thoughts, Joe, thanks.

DR. REISCHAUER: One small comment and then a

question. On this chart, how does fee-for-service Medicare compare to other payers? There was one box that surprised me by being blank, which was reimbursement relative to Medicaid.

DR. SCHOENMAN: I think I can explain that. There are a couple of things analytically behind this table. As I said, you had to have at least 10 percent of the patient type to even get in the analysis. So the n for the Medicaid column is about half, for one thing. I think that's what's driving it.

I think the other thing is just that. If you got in the analysis, you weren't accepting 40 percent Medicaid, so it wasn't as big of a deal for the few Medicaid patients that you had. It just didn't rise.

DR. REISCHAUER: So the Medicaid line is really a tough one, just because of...

My question/observation has to do with the acceptance of new patient chart and the comparison with private fee-for-service/PPO. We know that private fee-for-service is an endangered species. There aren't a whole lot of those folks out there. So what we're probably talking about is PPO here.

In this question, is this sort of do you accept new PPO patients for the group that you've already agreed to provide services for? And if that's the question, I would expect 99 percent, and I wouldn't expect to give you a particularly good comparison with -- I mean, I wouldn't get upset if Medicare was quite different, was lower than that. It's sort of like are you going to fulfill your contractual obligation or not kind of question.

So I think we can tolerate actually quite a difference here without being too upset. And what we really should be doing is comparing it to the other columns.

DR. NEWHOUSE: Why wouldn't that apply to the HMO group?

DR. REISCHAUER: Good point. Then you have reason to be even happier with the fee-for-service numbers here.

DR. HAYES: What was the point?

DR. SCHOENMAN: I didn't hear it.

DR. NEWHOUSE: I said why wouldn't that apply to the HMO group. That is, I'm not sure Bob's interpretation is right here.

DR. SCHOENMAN: The other thing that was interesting, I think if you look at the slides on the are you restricting access at all because of your concerns and

the red bars that we were seeing, how could you restrict access to private PPO patients? Well, you can do it in a couple of ways. You can just decide not to sign up with a given plan, or you can say I've capped my practice.

So there are ways to do it within those -- and the same thing exists, I think, for the HMOs.

DR. NEWHOUSE: I guess the difference may be that you accept the PPO if they come outside the PPO anyway, and pay your normal fees. That may be what this is reflecting.

MR. FEEZOR: Bob asked my question. I think we need to look behind when it says those are accepting, because when we do access surveys for some of our enrollees in certain areas, we find that if they, in fact, were under 65 and my patient then yes, I'm accepting. Or in some other instance, if it's a tight referral. So I think that is a concern.

And Glenn, to modify what you said, 5 percent of those accepting of those who in fact have a significant of amount of Medicare business. That's the other qualifier. So it's not a total set of the physician population.

The only other thing is I wonder if, in reacting to significant changes in the physician compensation, if there's not a natural time lag of about a year or so, at least in the group practice models -- and I'd refer to the real physicians in the group, Alan or Nick or Ray -- but certainly I think in California it would probably be that at the end of a year under the new reimbursement system there is sort of an evaluation of what that's done to the total practice revenue pattern. And it's at that point time the decision -- so in essence, responding to the 5.6 percent, we're likely to have next year I think, at least in the group model, is where you might see some impact in that.

Again, that's more of an intuitive thing. I would defer to people who really are part of more of the medical practice as to whether that would be the case or not.

DR. NELSON: I'm glad that you included the question about difficulty referring patients, because I think particularly with subspecialist proceduralists, that may be an important canary in the mine. And I hope that we'll continue to ask that question because I think it may be revealing as time goes by.

DR. STOWERS: My question had to do with the relationship between the Medicaid and the Medicare. As a practice starts making a decision on cutting back, the first

to go is the Medicaid patients and then the Medicare as they work more towards the private pay or the PPO, as they get into difficulty. And I think the Medicare patients, in a lot of practices, even though the reimbursement isn't that good, it still helps carry part of the Medicaid expenses in your practice.

So I'm wondering if there's some way that we can get a feel for how much this Medicare decrease also affected the decrease in the willingness to accept Medicaid. Because I would bet there's a relationship there. I would bet that nearly 100 percent of the people who decide to start restricting their Medicare practice are making a similar decision at exactly that same time to go ahead and drop Medicaid.

I don't know of any physicians that get to the point that they're restricting Medicare in their practice that they haven't either restricted or totally eliminated Medicaid out of their practice. So I think that this thing not only is affecting Medicare patient selection, but I would be there's a real strong correlation with Medicaid acceptance. That's my first point.

My second point is Medicaid, being a state level administered program with tremendous variance in payment and so forth, do we have enough numbers here? I haven't run them or whatever to get some state level data. But it would be interesting if some day we could see where the variance is and then see whether that is impact Medicare acceptance, also. I would also bet there's a correlation a lot different in different states regarding how much the Medicare population is being impacted.

DR. SCHOENMAN: Totally agree with you, unfortunately the numbers are just not going to be large enough to do that.

And the other point that I think you've touched on earlier today is acceptance -- Medicare either looks really good as a payer or not so good as a payer, depending on what market you're in and what the private fees look like in that market. And we can't say anything about that, either.

DR. STOWERS: I just didn't want us to take any comfort out of fact that Medicare was like Medicaid on here, and that there's been a decrease in both. I'm saying I think that's a natural response that it should have been. I don't think it gets anything off our back about the Medicare, I think because I think they're totally linked to each other, not independent.

MS. ROSENBLATT: When I hear about access problems I hear radiology mentioned. That was one of the specialty that we excluded from the study. I was just wondering why you were forced to exclude the various specialties?

DR. HAYES: We excluded radiologists, anesthesiologists, and pathologists because they are largely facility-based specialties, often have contractual arrangements with the facility where they work. And they just don't have much discretion over who they accept and don't accept. It kind of goes back to the point Alan was making earlier. It's the same idea.

There would be perhaps a host of interesting questions to ask about those specialties, but they but they would be different questions from the ones on this survey.

MR. HACKBARTH: Can I ask you a question about the survey sponsored by the Center for Health Systems Change? I think everybody got a copy of the issue brief.

What do we gain from our survey that we would not get from the survey that they do?

DR. HAYES: The first thing would be just the timing. They conducted their last survey spanning 2000-2001, and my understanding is that they will not conduct another survey again for at least a couple of years. So the timing of our survey, I think, was good because it happened after the fee cut.

DR. SCHOENMAN: We were in the field for five months, which is as long as we could stay in the field, and we really struggled with that to get the responses. They're in the field for, I think, 16 months for a given survey. It's the timeliness of the data, I think.

Now their advantage, of course, is they have much larger numbers.

MR. HACKBARTH: Which the size and the much larger numbers presumably would help to get at some of the locality issues and specialty issues in a way that we can't with a much smaller survey. I just wonder if there's some way not to supplant one with the other, but look at them as partners, as complements to one another, so that we get the maximum information for the Commission and for Congress.

DR. SCHOENMAN: I think we are finding things that seem to be consistent, that the access restrictions are not just Medicare, they're occurring for other sectors as well.

DR. HAYES: The other thing that they bring to the table, of course, is the market-specific work that they do. They go out, they interview people in each of these markets.

And so I think we want to kind of draw upon that in what we write up for the March report, and intend to do so.

MR. MULLER: It might be useful to also look at the supply data, not to have our own independent source of that but to look at that, because compared to let's say the literature in the mid to late '90s, when managed care was in its heyday and there was all this oversupply of physicians being forecast, the more recent studies are now indicating that there may be undersupply in a number of areas.

So again, that work is being done elsewhere but it might be useful to include that in our work. I'm not suggesting we do our own.

DR. HAYES: One measure of supply that we -- you're talking about overall supply of physicians, right?

MR. MULLER: Yes, but more importantly I think one has to look at it on a specialty basis overall. In that sense, it would not be sufficient. But yes, comprehensively, I would say overall

DR. ROWE: Do we distinguish in these surveys the elderly from the disabled?

DR. HAYES: No.

DR. ROWE: There are 5 million or so disabled; is that right? I'm just wondering whether or not that would be informative, or interesting in terms of it may be that there is a problem for access for the disabled, for instance, that we're not seeing because we're not distinguishing them as Medicare beneficiaries and they're swamped by the five or sixfold greater elderly population. I don't know that there is a concern.

But if our goal is to assess access to physician services for our Medicare beneficiaries, given the fact that there is this non-trivial important, but relatively small -- on a relative basis -- subpopulation of 5 million beneficiaries, it might be helpful, at least in the future, to see if we could ask about that subject.

DR. SCHOENMAN: I think there are other data sources that can speak to that question. It may be better addressed through a beneficiary survey, and CMS is undertaking that type of work. I'm virtually certain they're sampled both the disabled and the elderly special populations. It's very hard to ask a physician, to even get them to distinguish between the categories that we've used. And I think to ask them to make a further distinction would be very difficult.

DR. ROWE: That's fine. Thank you.

MR. SMITH: Julie, one quick question and two thoughts. The share reporting revenue declines, is that concerned on a per patient basis or is that a volume? So if someone were concerned that their overall practice was generating less revenue, where would they show up here?

DR. SCHOENMAN: You're talking about in response, do they know about the fee changes?

MR. SMITH: Right.

DR. SCHOENMAN: It was, how has that affected your Medicare revenue?

MR. SMITH: In aggregate or with respect to --

DR. SCHOENMAN: No, it's in the aggregate.

MR. SMITH: So if someone restricted her practice, they would show up here in having less Medicare revenue? This wouldn't simply be --

DR. SCHOENMAN: It's specifically tied -- it was linked to are you aware to the fee changes, yes or no. And if you said yes, have these fee changes increased your Medicare revenue a lot, a little, decreased it a little, decreased it a lot.

MR. SMITH: So it's specific to the fee change?

DR. SCHOENMAN: Yes, it is.

MR. SMITH: I just wanted to follow up on Jack's first comment. I'd be very surprised if the longitudinal data didn't show that reporting physicians were always concerned about billing paperwork and reimbursement. If they didn't, if we saw over time a significant change in that response, that would be important data. But it's not clear that, in the absence of an important change, that these reports aren't simply the reflexive state answer that you would always get. It would be very useful to try to come up with some way to test that.

MR. MULLER: I'm surprised it's so low, because even if you're happy about the reimbursement, you're worried it's being cut.

MR. SMITH: My other comment had to do with Alan's question of getting behind the data. It would seem to me it would be very important here, in some cases, to understand what share of a physician's total practice was Medicare. Not simply that it was more than 10, but that if it were a significant plurality of the practice, they might be more unhappy but less willing to restrict access.

Teasing out those interactions where we can, I think, would help make this data more useful to us.

DR. SCHOENMAN: You're absolutely right. We've

actually done some analysis and I think that some of those tables were in the materials that went out in the draft report, where we looked at some of these dependent variables by physician characteristics, including share of practice. And there really wasn't much that was showing up along those lines.

MR. HACKBARTH: But didn't it show that in fact if you had a higher percentage of your practice involving Medicare patients, that you were less likely to close off the practice?

DR. SCHOENMAN: I think that that was true.

MR. HACKBARTH: I seem to recall that as one of the findings.

Let me go back to this question that's nagging me, at least, of the variation across the country by locality and by specialty. This is helpful. This is a significant step forward in terms of having timely information on this particular pay cut, but it still leaves unanswered many questions.

In terms of having a monitoring system going into the future, I would expect that if we start to experience access problems in the area of physician services that they won't happen across the board, that they will happen in particular markets were private fees are relatively high or in particular specialties.

Any thoughts on how we can start to wrestle with that problem?

DR. HAYES: Yes. We seriously looked at the options on surveying particular market areas with this survey and we realized very quickly that there were two major difficulties here. One has to do with just picking the areas, trying to decide at the outset which areas do you survey?

And then the other one just has to do with the expense involved. We have to have 250, 300 responses from each locality, from each geographic area in order to make some statistical comparisons among areas. You can see there that it would just be very expensive. This survey was a major hunk of our major research budget, to just do this.

So with that, we have to turn to our colleagues in Baltimore here. CMS has some interesting projects underway that will help us, I think, in this area. They have, for example, access to 100 percent physician claims data and have the computing capability to summarize those data by state, by substate areas, by specialty. That's a tremendous

thing right there. And they can look at changes in billings for individual physicians, caseloads, that kind of stuff.

That then puts them in a position to identify places where there may be problems. Then they plan to do targeted beneficiary surveys in areas where either the claims data or anecdotes, reports from area agencies on aging, whatever it is, tell them that perhaps there's a problem. And they can go in and do those targeted beneficiary surveys and give us all some results about where there might be problems.

The interesting thing that falls out of that, of course, is what do you do from a policy standpoint? We have a national payment system here and it is sensitive to some market conditions, input prices. We have a bonus payment system for health professional shortage areas, that kind of stuff. But beyond that, it's not clear where we would go to fine tune the system.

But the first step, I think you're asking, is how do we at least detect the problems?

MR. MULLER: I think it's important to remember that the beneficiary access problems and issues sometimes are caused by factors that are not on this table at all. We talked earlier a little about the supply issues, and we do know about differential supply all around the country. But Manhattan is at one end and rural areas of Montana at another end these days.

And a lot of those supply issues aren't affected by things that Medicare can do, whether it has to do with lifestyle or educational opportunities for children, spouse, work possibilities, et cetera.

So when you look at the kind of supply issues around the country and how difficult it is to kind of rectify them with any single bullet, and how multifactorial those issues are -- and those, in many ways, are substantially outside the control of the Medicare program. So I don't think that Medicare should take it all upon itself to think that it's just these issues here that cause there to be differential access all around the country.

MS. RAPHAEL: I just had one comment. From what I gather from today, right now it appears that in the very short period of time it's become the conventional wisdom that there are problems with access to physicians. And you just kind of read about this not with any great grounding in data, but I think an accumulation of a number of studies and recent commentary has led to these kind of blanket

statements that I have seen with increased frequency.

So I want to better understand what we're going to add to this, and sort of shed light on. From what you said earlier, Glenn, I gather the main contribution we're making is the timing of our work, that this was done post-changes in physician payment. And therefore, it's much later than earlier studies that have been done in this area.

Is there anything else that we're doing that's going to help bring some more enlightenment to this area?

DR. HAYES: I think the key contribution the Commission can make is to take into consideration information like this and other assessments of payment adequacy and to advice the Congress on payments for physician services. I mean, I think that that's where we come in.

This by itself is just one source of information on access to physician services, and it's an important contribution with the timing, as you say. But it's the putting of that together with other things that makes your efforts very important, I think. Does that answer your question.

MS. RAPHAEL: I think it does.

DR. HAYES: The other thing is we're still sending copies of the report that Julie put together on the '99 survey, we're still sending that to Hill staff and to others. It's viewed as a valuable source of information for the decision makers.

DR. NEWHOUSE: Glenn, I think somewhat reinforcing your comment about cold comfort, there is some tension I think between the notion that there is a substantial access problem then volume continues to increase. One can take both of those facts and still come up with a story that would cause concern but it at least becomes a more strained story, I think.

DR. STOWERS: Just back to Kevin on the timing issue, it said in our materials that we would come back with a final report in November, to kind of use some material for the March 2003 report. But this is a very hot issue on the Hill right now, this fall. Are we making any plans to get this to the legislature decision makers? Is there any way that the Commission can kind of exit this concern not having to wait until next spring to do that kind of thing?

Even though we understand it's one study, but it is a study that the Commission has done and it seems to at least have a strong trend to it.

DR. HAYES: We routinely send the meeting briefs that go with these reports to Hill staff. I mean, they are aware -- not the report itself, but the meeting brief and we're in a position, of course, to respond from inquiries from Hill staff if they need further information on these documents. But they know, they're informed about what we're doing.

MR. HACKBARTH: Any other questions or comments? Okay, thank you very much.